**ASSOCIATION OF VILLAGE COUNCIL PRESIDENTS**
**VOCATIONAL REHABILITATION**

## ***APPLICATION FOR VOCATIONAL REHABILITATION SERVICES***

1. Name: _____
(First) (MI) (Last) (Maiden)
2. Age: _____ Date of Birth: _____

3. **PERSONAL:**
**Race:** ☐ Ak. Native/American Indian ☐ Caucasian ☐ African American ☐ Asian/Pacific Islander
**Sex:** ☐ M ☐ F **Martial Status:** ☐ Married ☐ Separated ☐ Never Married
Are you a U.S. citizen? ☐ No ☐ Yes If no, explain: _____

4. Home or Message Phone: _____(please note home or message number)

5. Mailing Address: _____
Street or P.O. Box City State Zip

6. Contact Person: _____ Address: _____ Phone: _____

7. Who Referred you to Vocational Rehabilitation? _____

8. Have you ever applied for vocational rehabilitation services before? ☐ Yes ☐ No
If yes, where? _____ When? _____ Counselor's Name _____
Services received: _____

I am requesting services from the AVCP Vocational Rehabilitation for the following disability:

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I am requesting the following types of services from the AVCP Vocational Rehabilitation:

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What will you accomplish as a result of receiving services?_____
_____

**By signing this application, I am requesting services from the AVCP Vocational Rehabilitation. I further certify that the information provided herein is correct.**

_____ _____
Signature of Applicant Signature of Representative (if applicable)

_____ _____
Date Date

**THIS SECTION TO BE COMPLETED BY THE COUNSELOR AT INTAKE**

***SUPPLEMENTAL APPLICATION INFORMATION***

**1. HOUSEHOLD INFORMATION:**

Number living in the house? _____ How many dependants? _____

| **Name** | **Relationship/Age** | **Name** | **Relationship/Age** |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

Are any of the above in another residence? ☐ No ☐ Yes If yes, type? _____

**2. HEALTH INFORMATION:**

Are you covered under Indian Health Services (IHS) ? ☐ No ☐ Yes
Do you have health insurance? ☐ No ☐ Yes
If you are working, is health insurance available through your job? ☐ No ☐ Yes

Personal Doctor and other doctors/hospitals who are familiar with applicants condition:

| | Name | Address | Last Seen |
|---|---|---|---|
| a. | | | |
| b. | | | |
| c. | | | |

Date when disability began?_____

Is disability a result of a work related injury? ☐ No ☐ Yes

If yes, date of the accident? _____ Employer

_____ Currently taking medication ? ☐ N o ☐ Yes If yes,

what type? _____ Currently under treatment? ☐ No ☐ Yes If yes,

what type? _____ Do you use substances such as alcohol or drugs? ☐ No
Can applicant travel without assistance/escort? ☐ No ☐ Yes explain:_____
☐ Yes
Receiving personal care attendant services? ☐ No ☐ Yes If yes, Hrs/day _____

**3. EDUCATION:**

Highest grade completed: _____ Date of Graduation:_____
GED? ☐ No ☐ Yes If yes, date received _____

Were you in Special Education? ☐ No ☐ Yes Name of school_____

List any other schools attended:

| School | Degree/Certificate | Dates Attended |
|---|---|---|
| | | |
| | | |
| | | |

**4. EMPLOYMENT INFORMATION – Employment status**

____ Self Employed ____Working ____ Not working ___ Student ____ Other
Please explain other: _____

**Employment history** (recent job first)

Employer _____ From_____ To _____
Address _____ Reason for leaving _____
Job Duties _____
_____Hourly Wage $_____

Employer _____ From_____ To _____
Address _____ Reason for leaving _____
Job Duties _____
_____Hourly Wage $_____

Employer _____ From_____ To _____
Address _____ Reason for leaving _____
Job Duties _____
_____Hourly Wage $_____

Employer _____ From_____ To _____
Address _____ Reason for leaving _____
Job Duties _____
_____Hourly Wage $_____

May we notify your recent employer? ☐ No ☐ Yes If no, please explain: _____
_____

**5. LEGAL:**

Do you have a valid Alaska's Drivers License? ☐ No ☐ Yes If yes, number _____
Do you have your own transportation? ☐ No ☐ Yes
Have you ever been convicted for a DWI/DUI? ☐ No ☐ Yes
Have you ever been arrested or convicted? ☐ No ☐ Yes
If yes, explain: _____What year(s)_____

If yes to either of the above, are you currently on probation or parole? ☐ No ☐ Yes

**6. VETERAN:**

Are you a Veteran? ☐ No ☐ Yes
If yes to the above, note branch of service, type of discharge, and period served:_____

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**7. FINANCIAL:**

Do you or any of the residents receive any assistance from the following sources?

| (Source) | (Type) | (Monthly Amount) | (How Long) |
|---|---|---|---|
| Public Assistance | | | |
| TANF | | | |
| ASHA Housing | | | |
| Worker's Comp. | | | |
| Social Security | | | |
| Annuity/Private Insurance | | | |
| Veteran's Benefits | | | |
| Food Stamps | | | |

What is your primary source of support? _____

***If at anytime you start receiving additional resources (i.e. unemployment, energy assistance, TANF, settlements, etc.), you need to contact our office with that information right away for our records.**

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# CERTIFICATION

**The consumer has been provided the following information:**

**1. A general overview of the VR process ____**
**2. How one gets in to the VR system ____**
**3. The responsibility of the consumer ____**
**4. The services which are offered by VR ____**
**5. The rights of an applicant/consumer of VR ____**
**a) The Client Assistance Program (CAP)**
**b) How to appeal a decision of action of VR**
**c) Confidentiality of information**
**6. Other VR services (DVR)____**

( VR = Vocational Rehabilitation)

_____ _____

**Counselor Signature** **Date**

**The above topics have been explained to me at the time of orientation/intake to Vocational Rehabilitation. I understand the rights and responsibilities I have as an applicant/consumer of the AVCP Vocational Rehabilitation and am willing to abide by them.**

_____ _____

**Applicant/Representative Signature** **Date**

# AVCP VOCATIONAL REHABILITATION

## Authorization To Release Information

For the purpose of documenting a disabling condition, for use in the determination of eligibility for services through the Association of Village Council Presidents Vocational Rehabilitation Program, and for exchange of information for service plan development and ongoing services. I _____, applicant (please print) DOB _____ request the release of information to be exchanged as required between AVCP Vocational Rehabilitation Program and:

Yes / No (**please intial**)

____/____ 1. YKHC and/or Indian Health Services Medical Records

____/____ 2. YKHC Behavioral Health

____/____ 3. YKHC Developmental Disabilities Program

____/____ 4. YKHC Audiology

____/____ 5. YKHC Phillips Alcohol Treatment Center (PATC)

____/____ 6. Alaska Psychiatric Institute (API)

____/____ 7. Dr. Sarah Angstman, Psychologist

____/____ 8. Dr. Lorin Bradbury, Psychologist

____/____ 9. State Division of Vocational Rehabilitation Program

____/____ 10. State Division of Public Assistant Program

____/____ 11. _____School District

____/____ 12. Other agencies involved_____

_____ _____

Signature of Applicant Date Representative (if applicable) Date

***** This document will expire at time of closure.